Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SHANNON MEDICAL CENTER
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
Insurance Co of North America

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-0856-01

MFDR Date Received
November 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on their payment of $6,048.90, for the APC a supplemental payment is still due of $1,725.73 for the APC allowable still due."

Amount in Dispute: $1,725.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Receipt of Medical Fee Dispute acknowledged however, no response submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2011	Outpatient Hospital Services	$1,725.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.402(d) sets out coding, billing, and reporting, of facility services covered in this rule.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 8, 2011
   - B15, RN – Procedure/Service is not paid separately. Not paid under OPPS; services included in APC rate
   - W1 – Workers' Compensation State Fee Schedule Adj.
   - 59, RT, 97, R79 – Distinct Procedural Service. Charge included in another Charge or Service, CCI

Standards of Medical / Surgical Practice, Right Side.

- 129, Denial/Reduction due to submission/billing error. Invalid code for CMS payment – resubmit.

Explanation of benefits dated October 6, 2011

- 193, B15, RN – Original payment decision maintained. Procedure/Service is not paid separately. Not paid under OPPS; services included in APC rate.
- 125, 193 RM7 – Denial/Reduction due to submission/billing error. Original payment decision maintained. Invalid doe for CMS payment-resubmit w/valid code.
- 168, 193, RT – No additional allowance recommended. Original payment decision maintained. Right Side.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code A4566 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,336.55. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,001.93. This amount multiplied by the annual wage index for this facility of 0.8441 yields an adjusted labor-related amount of $1,689.83. The non-labor related portion is 40% of the APC rate or $1,334.62. The sum of the labor and non-labor related amounts is $3,024.45. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.219. This ratio multiplied by the billed charge of $4,969.00 yields a cost of $1,088.21. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,024.45 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $3,315.25. The allocated portion of packaged costs is $3,315.25. This amount added to the service cost yields a total cost of $4,403.46. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $3,024.45. This amount multiplied by 200% yields a MAR of $6,048.90.
   - 28 Texas Administrative Code 134.402(d) states in pertinent part, “for coding, billing, and reporting, of facility

services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service." The procedure code 29822 included the "59" modifier. American Medical Association Current Procedural Terminology (AMA CPT) describes the 59 modifier for use in identifying procedure/services that are not normally reported together, and that are not ordinarily encountered or performed on the same day by the same physician. According to Medicare Learning Network Matters (MLN) Number, SE0715, the 59 modifier must be supported by documentation that indicates a different session, different surgery, different anatomical site or organ system, separate incision/excision, different agent, different lesion, or different injury or area of injury. Review of the document titled "Operative Report" finds that the requestor does not support that the service in dispute represents a separate service. The division concludes that the requestor did not meet the requirements of 28 TAC §134.402(d) therefore, additional reimbursement cannot be recommended.

- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2795 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7050 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is $6,048.90. This amount less the amount previously paid by the insurance carrier of $6,048.90 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.